STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

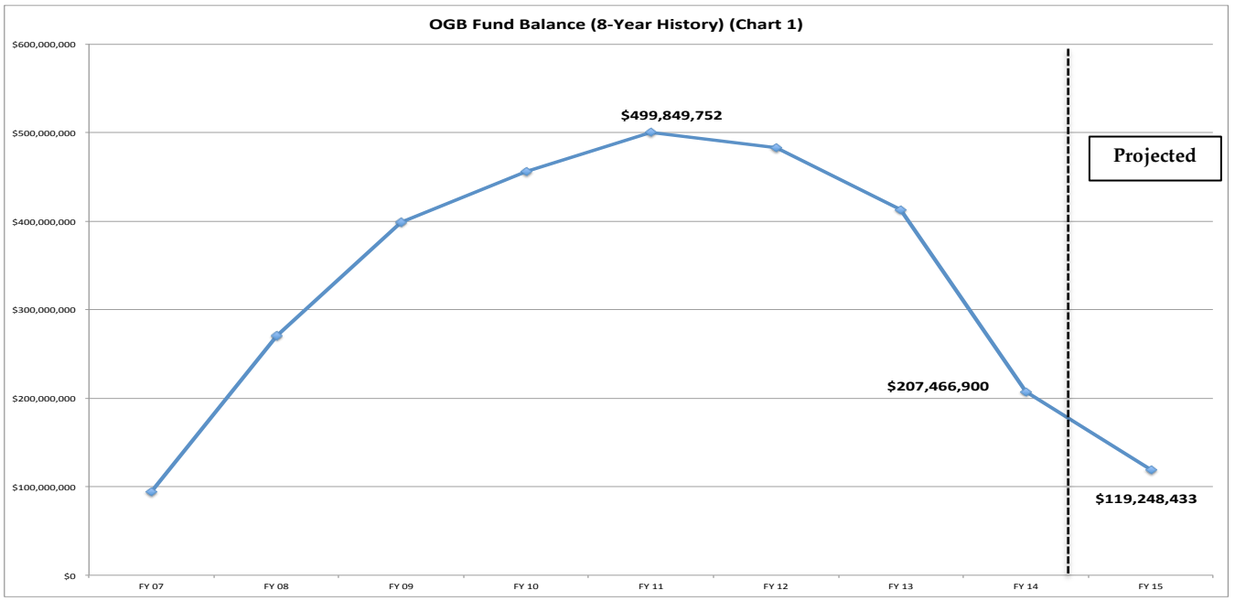
TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: September 23, 2014

SUBJECT: Office of Group Benefits (OGB) Update **REVISED**

OGB finished FY 14 with a $16.2 M per month negative burn rate, which resulted in the overall fund balance decreasing approximately 48%, or $194 M, from $402 M as of July 1, 2013 to $208 M as of June 30, 2014. OGB's FY 14 total expenditures grew 8.1% from FY 13, while its FY 14 total revenues decreased 1.4% from FY 13. OGB's overall 6-year trend of expenditure growth is still 6% annually, while its revenues have grown only 0.7% over that same 6-year time frame. As has been previously discussed, the main reason for the decrease in the OGB revenue growth is due to premium decreases of 7.11% in FY 13 and 1.8% in FY 14. Chart 1 below depicts an 8-year history of OGB's fund balance and the projected FY 15 ending year fund balance inclusive of DOA/OGB health plan changes.



Using FY 14 actual revenue/expenditure data as the base year, to the extent FY 15 expenditures increase by the 6% trend and the anticipated savings actually occur from plan changes, the FY 15 ending year OGB fund balance would be approximately $119 M, which equates to a $7.4 M anticipated "negative monthly burn rate" in FY 15 (or $88.2 M annually) after health plan changes.

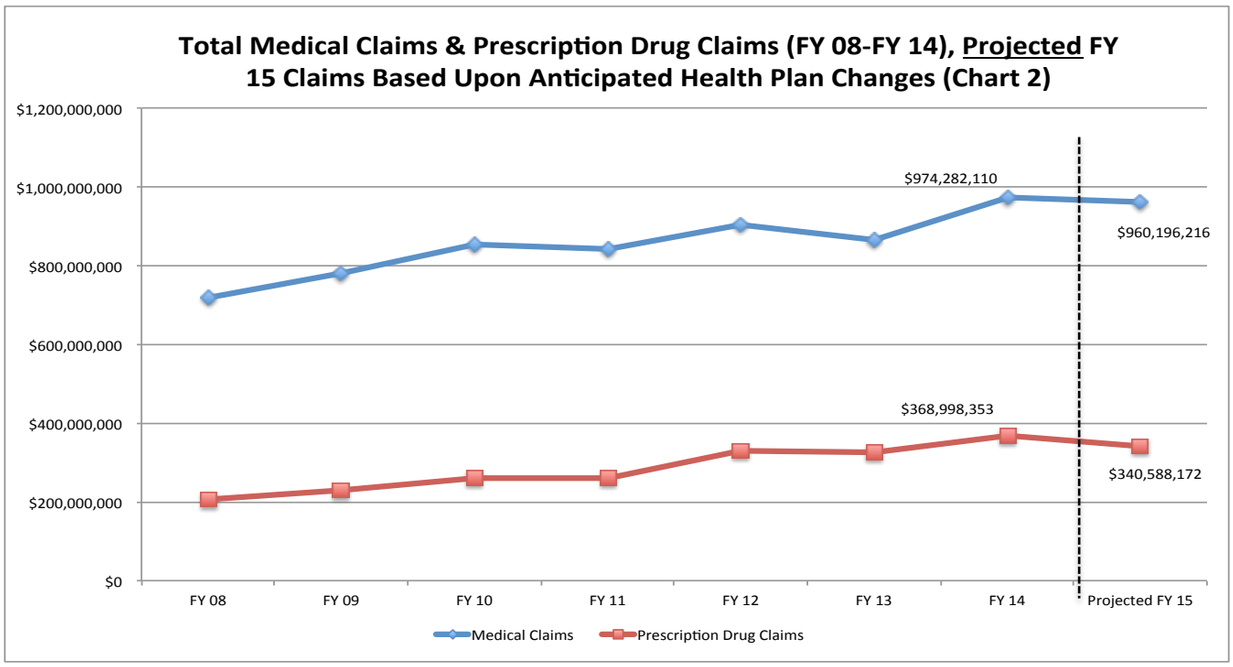
TABLE 1

FY 15 Projected Fund Balance	FY 13 Actual	FY 14 Actual	FY 15 w/6% Exp. Growth	FY 15 Health Plan Changes*	FY 15 Projected
Total Revenues	$1,263,912,119	$1,246,394,217	$1,246,394,217	$57,900,000	$1,304,294,217
Total Expenditures	$1,333,324,904	$1,440,672,343	$1,527,112,684	($134,600,000)	$1,392,512,684
Fund Balance Impact	($81,058,082)	($194,278,126)	($280,718,467)		***($88,218,467)***
Ending Year Fund Balance	**$401,745,025**	**$207,466,900**			***$119,248,433***

**The $57.9 M in revenues is due to the 5% premium rate increase effective July 1, 2014. The ($134.6 M) is based upon anticipated cost savings from the prescription drug changes in the amount of $69 M, other benefit reductions and health plan changes listed in Table 2 on page 2 in the aggregate amount of $62.8 M and anticipated administrative cost savings identified in the A&M Report due to the OGB reorganization in the amount of $2.8 M.*

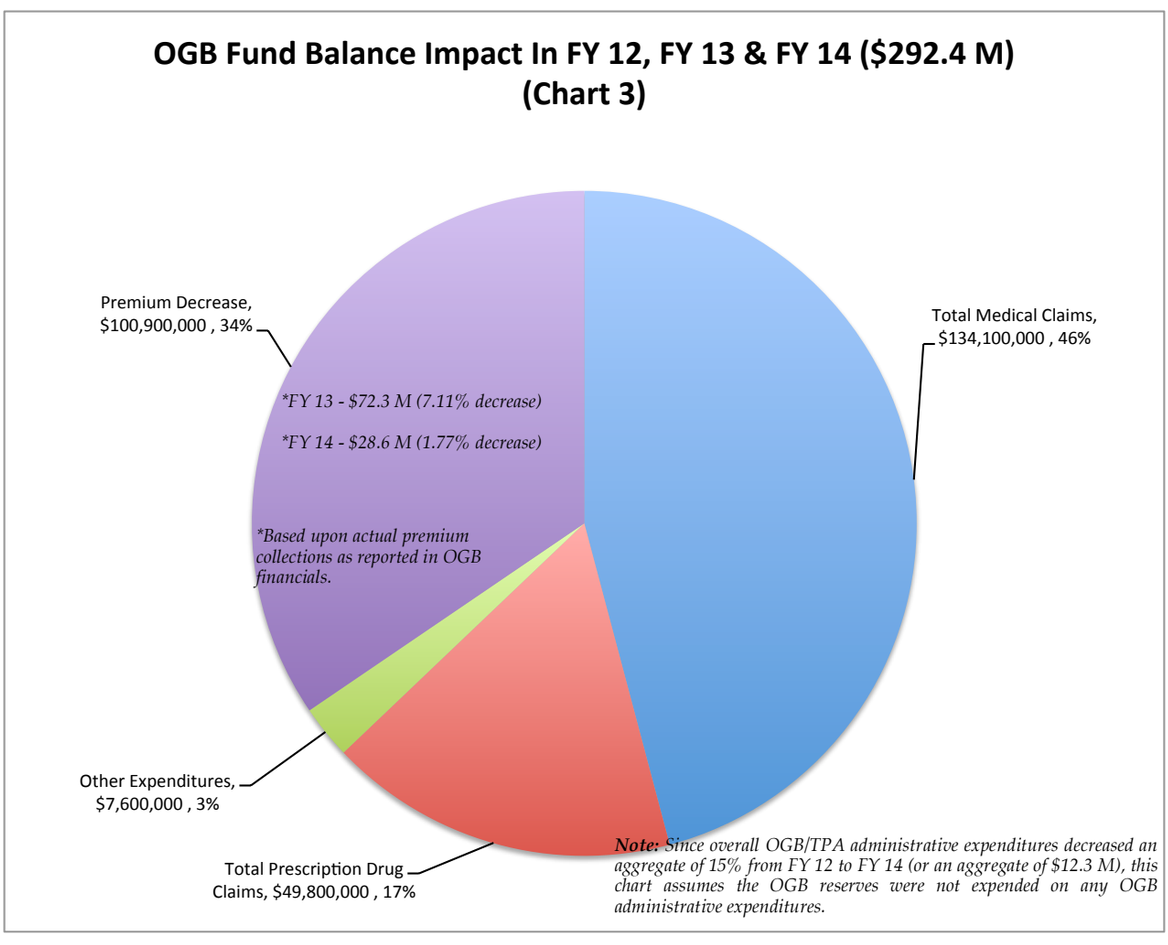
Since the majority of the anticipated health plan changes will impact either medical claims or prescription drug claims, Chart 2 on the next page depicts the anticipated medical/prescription drug claims payments in FY 15 inclusive of plan changes. Assuming FY 15 medical and prescription drug claims increased by the 6-year trend (5% increase in medical, 11% increase in prescription drug) and the anticipated savings from the plan changes actually materialize in FY 15, the medical claims may decrease by 1% and prescription drug claims may decrease by 8%. These savings will result from: 1.) Decreased utilization, 2.) Increased member cost share (increased deductibles, out-of-pocket maximums, copayments and a prescription drug formulary).

Note: *See page 8 of this document for an illustration of* ***only*** *increasing premiums to solve the negative burn rate as opposed to the combination approach that is being recommended by the DOA/OGB.*



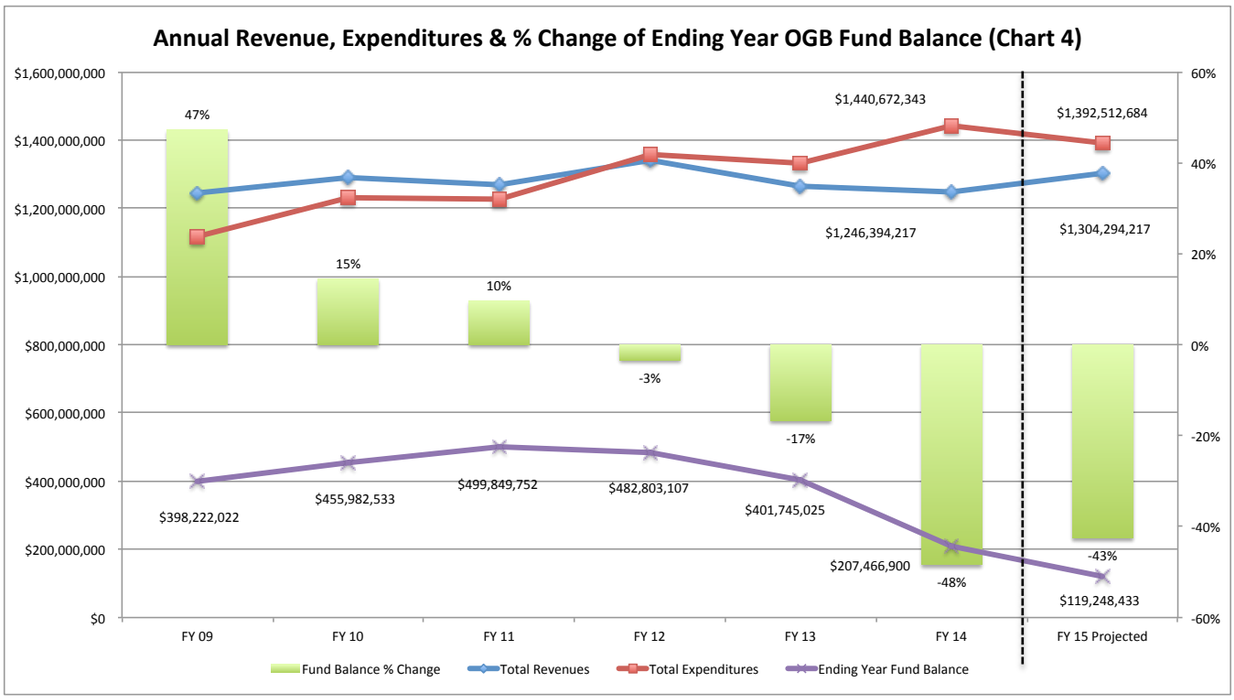
EXPENDITURES OF THE OGB RESERVES

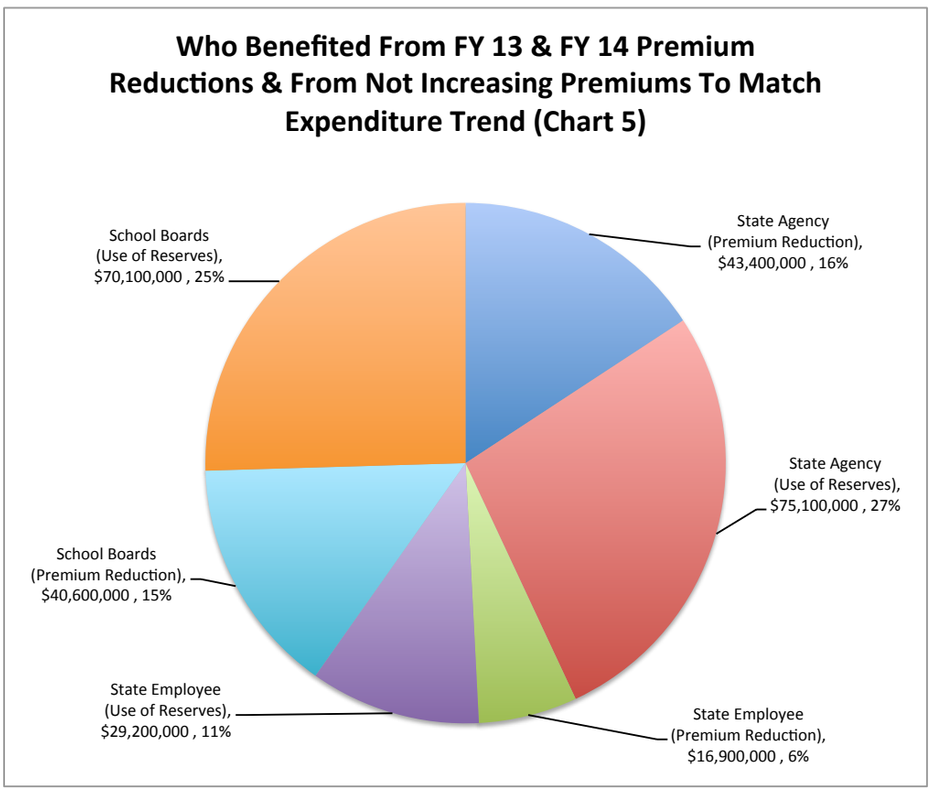
The FY 11 ending year fund balance was $499.8 M, while the FY 14 ending fund balance is $207.5 M. This equates to a $292.4 M reduction in the fund's reserves from the end of year FY 11 to the end of year FY 14. Since the OGB resources are *fungible*, it is difficult to calculate the specific expenditures paid by the fund. *Fungible* is defined as the state of being interchangeable, which means the original identity of the source of funding is lost when deposited into the OGB fund. One method to determine the expenditures of the $292.4 M reserves is to use a pro-rata share of prior year actual expenditures. From FY 12 to FY 14, OGB expended on average the following: 70% on Medical Claims, 26% on Prescription Drug Claims and 4% on Other Expenditures. These percentages were applied to $191.5 M, which is calculated as follows: $292.4 M (fund balance reduction) - $100.9 M (premium decrease) = $191.5 M. Since overall OGB/TPA administrative expenditures decreased an aggregate of 15% from FY 12 to FY 14 (or an aggregate decrease of $12.3 M), Chart 3 below assumes the OGB reserves were not expended on any OGB administrative expenditures. ***Note:*** *There are different methods to calculate the expenses of the $292.4 M reserve expenditures over a 3-year timeframe (FY 12, FY 13, FY 14). Chart 3 below is one example of how this information can be presented.*



WHO BENEFITED FROM PREMIUM REDUCTIONS?

As has been previously discussed, Chart 4 on the next page depicts that OGB's expenditures in FY 12 began to be higher than the amount of revenues being collected by the program, which resulted in





the OGB program living on reserves. The green bars in Chart 4 represent the percent change in the OGB's overall fund balance amount by fiscal year. Along with increasing expenditures, another reason for the decrease in the OGB fund balance during these fiscal years is due to premium reductions of 7.11% in FY 13 and 1.77% in FY 14. The state, state employees and school boards all benefited from these premium reductions. Based upon OGB FY 13 and FY 14 financials, the premium decreases have resulted in a total revenue loss of approximately $100.9 M ($72.3 M – FY 13, $28.6 M – FY 14), while the remaining fund balance depletion is due to average annual expenditure trend increase of approximately 6% not being funded through premium increases.

Based upon OGB historical pro-rata share percentages among state agencies, state employees and school boards, the benefit of the rate decreases and by not increasing premiums to fund expenditure trend is depicted in Chart 5.

Note: *The aggregate fund balance depletion from the FY 12 ending year balance to the FY 14 ending year balance is approximately $275.3 M. This depletion occurred during FY 13 and FY 14, which are the fiscal years during which the premium decreases were implemented. The FY 12 ending year fund balance was $482.8 M. The fund balance was $499.8 M at the end of FY 11. The $17 M difference between the FY 11 ending year fund balance and the FY 12 ending year fund balance is the negative 3% change in fund balance as depicted within the chart above (green bars). This reduction within the fund balance occurred prior to the implementation of the premium decreases.*

Chart 5 demonstrates that state agencies, state employees and school boards (employees/local school board entities) all benefited from the premium reductions. The total benefit depicted in Chart 5 in the amount of $275.3 M (aggregate fund balance change from ending FY 12 to ending FY 14) represents a net benefit from premium reductions in the amount of $100.9 M and the net benefit of using reserves in the amount of $174.4 M instead of funding the average expenditure trend increase with premium increases.

AMENDMENTS TO ACT 13 (HB 1) OF 2012 REGULAR LEGISLATIVE SESSION

Although there is no specific language in any prior year appropriations bill (Act 13 of 2012 RLS, Act 14 of 2013 RLS) or funds bill that directs the State Treasurer to transfer funds from the Office of Group Benefits into other state funds for expenditure, by not funding OGB's anticipated growth in expenditures (average of 6% annually) and by reducing premiums an aggregate 8.88% (7.11% + 1.77%=8.88%) within a 2-year timeframe, OGB was required to expend its reserve to pay for its expenditures. This method reduced overall state expenditures within the budget, which resulted in funding becoming available for other purposes. For example, language contained in Act 13 of 2012 (HB 1 –Section 18(D)), which is the budget for FY 13, reads as follows: *The commissioner of administration is hereby authorized and directed to reduce the State General Fund (Direct) appropriations contained in each department and budget unit contained in this Act and the Ancillary Appropriations Act for the office of group benefits for annual premium rate decreases to achieve a State General Fund (Direct) savings of not less than $22,000,000.* This language is due to the 7.11% premium decrease effective July 1, 2012 (FY 13 budget), which allowed $22 M of SGF resources to be used in other areas of the state budget.

Note: *R.S. 42:854 (C) provides that OGB's fund balance may not be utilized for the state's operating budget. Notwithstanding any other provision of law to the contrary, any money received by or under the control of the Office of Group Benefits shall not be used, loaned or borrowed by the state for cash flow purposes or any other purpose inconsistent with the purposes of the proper administration of the Office of Group Benefits.*

Note: *Based upon FY 13 actual revenue collections, the 7.11% premium reduction resulted in a total loss of premium revenues to the OGB in the amount of $72.3 M.*

Note: *A House Appropriations Committee Amendment to HB 1 during the 2012 Regular Legislative Session provided for SGF savings of $10.2 M and a Senate Finance Committee Amendment provided for an additional $11.8 M of SGF savings for a total of $22 M. These savings are attributable to the 7.11% premium decrease effective in FY 13.*

The FY 14 1.77% premium reduction was built into the Executive Budget. Based upon the Executive Budget documents and reviewing all group benefits budgetary adjustments, this premium reduction resulted in SGF savings of approximately $7 M. Based upon OGB FY 13 and FY 14 financials, the premium decreases resulted in a total revenue loss of approximately $100.9 M ($72.3 M – FY 13, $28.6 M – FY 14) of which a total of $29 M may be attributed to SGF.

PROJECTED FISCAL IMPACT OF HEALTH PLAN CHANGES

Due to the current negative monthly "burn rate" of $16.2 M, the Office of Group Benefits (OGB) is implementing various health plan changes. As has been previously discussed by the LFO, all of these changes are anticipated to result in approximately $190 M of annualized OGB savings in FY 15. Table 2 below is a listing of the changes and the anticipated dollar savings associated with each change. ***Note:*** *Specific details of these changes have been discussed in previous LFO reports to the JLCB.* Approximately 90% of the anticipated savings is due to 3 items. These items include: 5% premium increase - $57.9 M (31%), health plan design changes (changing health plan option choices) - $44.7 M (24%) and prescription drug changes (drug formulary) - $69 M (36%).

ALL OGB PLAN CHANGES (in millions) (Table 2)	FY 15
BCBS Medical - Prior Authorization	$1.0
BCBS Medical - Benefit Limits	$1.7
Rx-Formulary Design	$21.5
Rx-Formulary Design Conversion	$21.7
Rx-90 Fill option	$9.0
Rx-Clinical Utilization	$10.8
Rx-High Compound Mgmt	$3.4
Rx-Over Utilization Mgmt	$1.2
Rx-Acetaminophen Mgmt	$1.1
Rx-Polypharmacy Mgmt	$0.1
Rx-Exclude Medical Food	$0.2
Premium Increase (Additional Revenue) (Effective July 1, 2014)	$57.9
BCBS Medical-Plan Design	**$44.7**
BCBS Medical-Remove Vision	$5.3
BCBS Medical-Remove Standard Excluded Benefits*	$0.5
Communicate Health Retiree Medicare Exchange Option	$9.6
TOTAL	**$189.7**

Total prescription drug changes equate to $69 M.

**Examples of standard excluded benefits include: TMJ, acupuncture, impacted teeth, prior authorization of massages.*

As is indicated in Table 2 above, the DOA/OGB anticipates the health plan design changes to result in total annual OGB programmatic savings of $44.7 M. These savings will materialize in two distinct ways:

- ***Utilization will likely decrease*** – Based upon academic studies, if more OGB members enroll in the consumer driven plan options (HRA 1000, HSA 775), the members will likely become more aware of the cost of medical services and/or prescription drugs and could change behavior. This may result in an overall OGB medical claims cost decrease as members with these plans know and understand they only have finite resources (HSA/HRA account) to

consume healthcare. This may result in more cost-effective healthcare decisions by the member. However, this anticipated outcome needs to be balanced against plan members potentially not going to the doctor due to lack of HRA/HSA funds available for care, which could result in medical costs in the future.

- ***Cost shift*** **–** By increasing deductibles, increasing the out-of-pocket maximum and increasing copayments, the new health plan options will significantly reduce the cost to OGB, while the OGB member pays more for medical services.

OGB MEMBER TOTAL COST EXPOSURE

The total potential cost to the OGB member is calculated based upon the total annual premiums paid and the total health plans' out-of-pocket maximum. Table 3 and Table 4 compare the current plan options to the proposed plan options relative to total out-of-pocket costs for active single and family. These tables represent the potential maximum cost exposure to the OGB member. To the extent the individual's (or family) utilization is not significant, the out-of-pocket maximum increase being proposed would have a minimal impact. However, as has been reported in previous LFO OGB reports, these tables illustrate significant expenditure exposure to the OGB member, which is greater under the proposed health plan options than current plan options.

Another Perspective

According to the DOA/OGB, of the total HMO members, in plan year 2013 approximately 7% had an in-patient hospital stay and an aggregate 3% reached the current out-of-pocket maximum. The DOA/OGB contends these increases in the out-of-pocket maximums would only impact a small number of the total OGB population, which consists of approximately 230,000 lives.

TABLE 3 (ACTIVE SINGLE)

Active SINGLE	Annual Premiums Paid	Out-of-pocket Maximum	Total Potential Costs
Current HMO Plan	$1,683	$1,000	$2,683
Current PPO Plan	$1,782	$1,500	$3,282
Proposed HRA 1000*	$1,182	$4,000	$5,182
Proposed HSA 775**	$1,259	$4,225	$5,484
Proposed Local	$1,604	$3,000	$4,604
Proposed Local Plus	$1,684	$3,000	$4,684
Proposed Open Access	$1,782	$3,000	$4,782

TABLE 4 (ACTIVE FAMILY)

Active FAMILY	Annual Premiums Paid	Out-of-pocket Maximum	Total Potential Costs
Current HMO Plan	$5,858	$3,000	$8,858
Current PPO Plan*	$6,202	$5,500	$11,702
Proposed HRA 1000*	$4,114	$8,000	$12,114
Proposed HSA 775**	$2,955	$9,225	$12,180
Proposed Local	$5,582	$9,000	$14,582
Proposed Local Plus	$5,858	$9,000	$14,858
Proposed Open Access	$6,202	$9,000	$15,202

**The out-of-pocket maximum for the HRA 1000 plan is $5,000 active ($10,000 family). Due to the state providing $1,000 for an active ($2,000 family) in an HRA to pay for health services, the net out-of-pocket max is less.*
***The out-of-pocket maximum for the HSA 775 plan is $5,000 active ($10,000 family). Due to the state providing $200, plus a $575 dollar-for-dollar state match to the account to pay for health services, the net out-of-pocket max is less. Also, these tables assume the individuals/family will put $575 of additional resources into the HSA. This additional $575 is accounted for in the "premiums paid" column of the tables.*
****Current PPO Family plan is a family of 4 in table above.*

CONSUMER DRIVEN HEALTH PLANS

Two of the proposed statewide health plan options are *consumer driven health plans*. The HSA 775 plan has a Health Savings Account (HSA), while the HRA 1000 plan has a Health Reimbursement Arrangement (HRA). These plans came into existence in 2002 (IRS Ruling on HRAs) and in 2003 as HSAs were created within the Federal Medicare Modernization Act. Since the OGB default health plan (if an OGB member does not make a plan selection) is the HRA 1000 and due to the premium structure of the new plan offerings financially incentivizing members to move to these consumer driven type plans, the LFO will present two different perspectives of these health plan designs.

Perspective #1: Consumer driven health plans are built around high-deductible insurance products and have price-sensitive demand for medical services (Buchmueller, 2009). ***Note:*** *All resources utilized for this analysis are listed on page 9*. Proponents of these health plan types argue that patients will be "more prudent purchasers of health care by giving them 'skin in the game'"(Buchmueller, 2009). The overall trend of consumer driven health plans has been gradually increasing in the private sector. According to the January 2014 health insurance census conducted by *American Health Insurance Plans (AHIP) Center for Policy and Research*, HSA qualified enrollment has increased from approximately 3.2 million individuals in January 2006 to 17.4 million in January 2014. For context, according to health plan data from the Kaiser Family Foundation, in 2012 there are a total of 170 million individuals covered by private/public sector health insurance (non-Medicaid/non-Medicare). Based upon the AHIP survey report, consumer driven plans cover approximately 10% of that population. Also, these plan types are now starting to be offered in the public sector as is reported in the *State Employee Health Plan Spending Report* by the PEW Charitable Trusts. There are now 19 state governments that offer these plan types to their employees. ***Note:*** *OGB currently offers a consumer driven plan (CDHSA). However, only 0.14% (or 350) of the current OGB population is enrolled.*

Since consumer driven plans are designed so that, except for catastrophic expenses, employees have some responsibility of paying their own health-care costs with these accounts (HRA/HSA), the idea of *consumerism* enters into the patient's decision making (Barro, 2011). Consumerism is "the tendency of consumer-directed health-plan members to spend health dollars more judiciously" (Barro, 2011). The idea is since the patient has more *skin in the game*, the patient will make healthcare decisions differently with the added financial disincentive.

Perspective #2: According to the Centers for Disease Control (CDC), chronic conditions are

responsible for 75% of health care costs. Consequently, there is legitimate concern that patients with chronic conditions may not choose a consumer driven health plan. According to a study published in the December 2013 edition of the *American Journal of Managed Care*, patients that moved from a traditional health plan to a consumer driven plan with an HSA had reduced prescription drug adherence for prevalent chronic conditions. The study evaluated the impact of moving from a traditional health plan to a consumer driven health plan for medication adherence of individuals with chronic conditions. The study indicated, "increased patient cost-sharing is associated with decreased health services utilization" (Fronstin et al, 2013). Basically, use of prescription drugs by individuals with chronic conditions declined when patients became subjected to higher out-of-pocket costs.

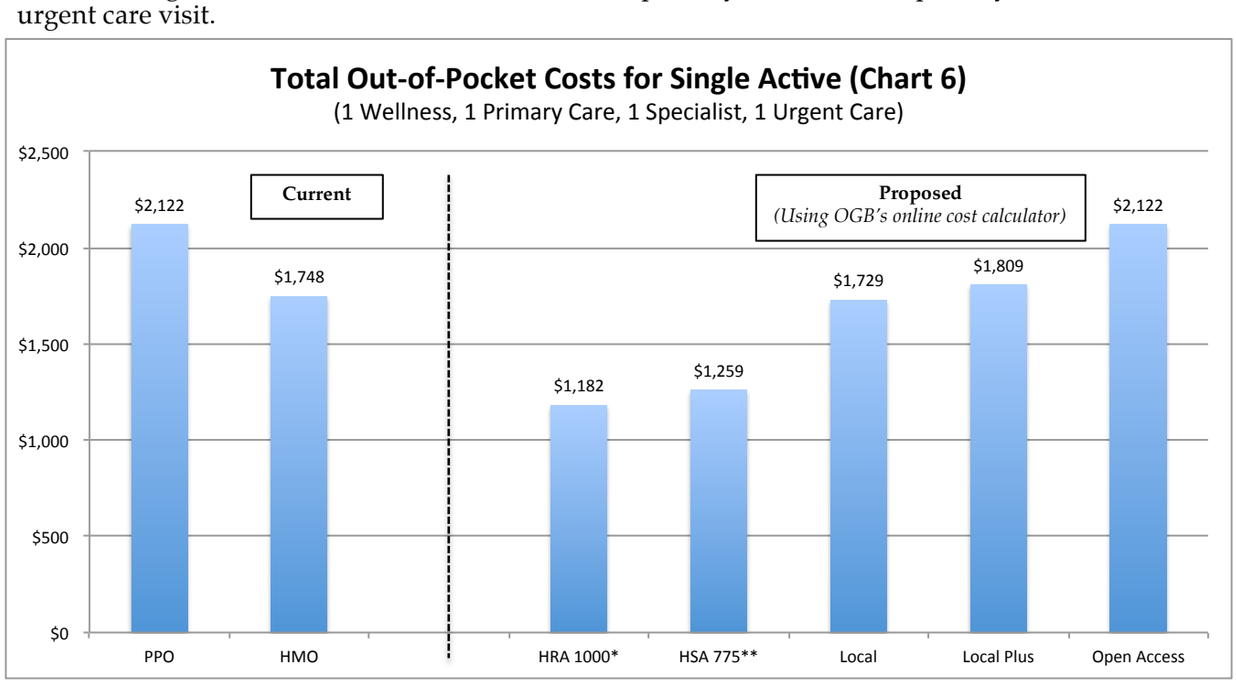
Other academic studies and surveys completed depict that consumer driven health plans may result in patients "skipping a recommended doctor's visit" (Iskarpatyoti, 2010). Other studies have shown that "patients with higher deductibles cut back on visits, tests, prescription drugs and specialist care" (Geyman, 2012). Skipping recommended visits may result in future unintended indeterminable medical costs in subsequent years. Since the majority of consumer driven health plans typically attract healthier populations through adverse selection, this specific unintended consequence has been difficult to prove empirically. Overall, opponents of these plan types argue that due to the "greater exposure to out-of-pocket costs," patients could be discouraged from seeking care (Charlton et al, 2011).

Consumer Driven Plan Conclusion

Both perspectives of consumer driven health plans are reflected in academic studies and research. There is no consensus among the academic community as to the impact on utilization and health care costs as a result of these plan types. However, if more individuals within the OGB enroll within these plans, overall medical service utilization could be reduced. As the plan members enroll within these plans, the members will be required to pay higher deductibles, coinsurance and out-of-pocket maximums and behavior could change from either not seeking care, delaying care or potentially modifying recommended care to the less costly option. Although the potential does exist for participating members in these consumer driven plans to build up personal reserves through HRA/HSA contributions, there may be a potential financial risk to the member in year 1 from switching from a traditional plan to a consumer driven plan if an unforeseen health event occurs during that year.

RISK IN SELECTING A HEALTH PLAN

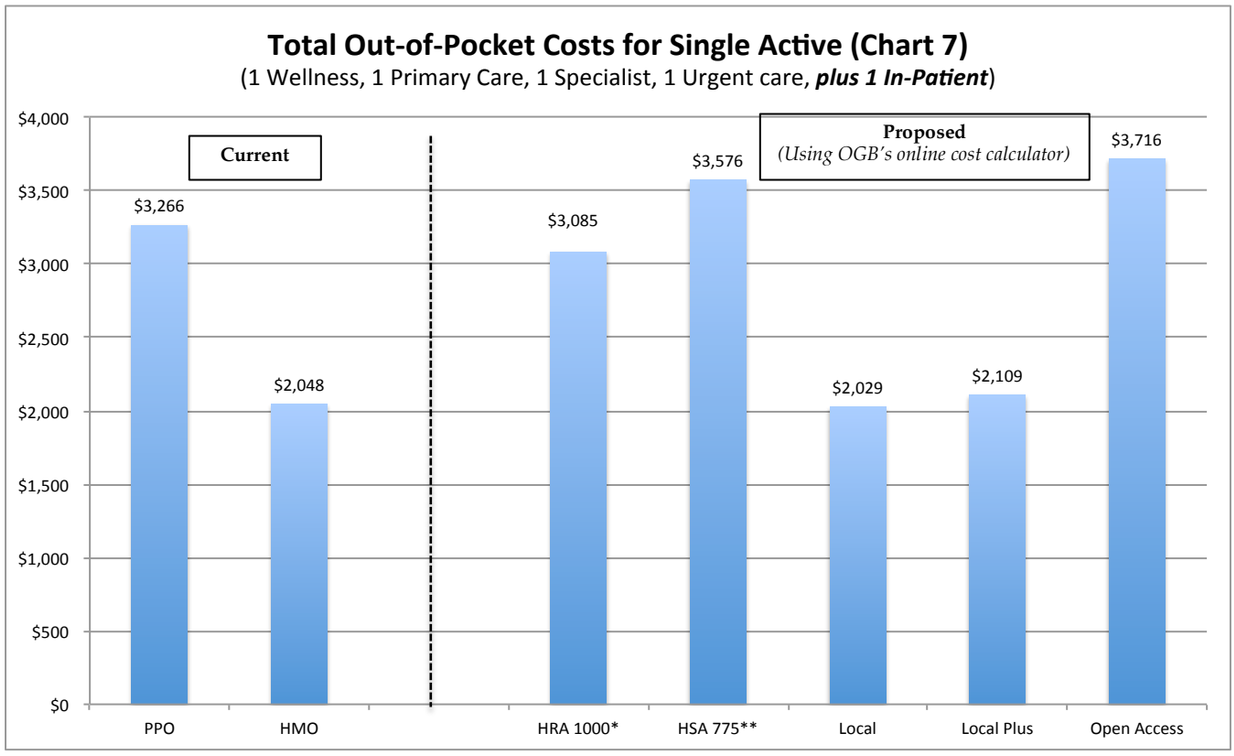
Although the new health plan options significantly increase the out-of-pocket maximums compared to current health plan offerings, if the OGB member and dependents are not significant users of medical services, selecting a consumer driven health plan (discussed above) may save the member overall total out-of-pocket costs. However, there may be a potential financial risk to the member in year 1 when switching from a traditional plan to a consumer driven plan if an unforeseen health event occurs during that first year. See bar charts below that utilize the OGB's scenario calculator to illustrate the level of risk taken. Chart 6 calculates the total out-of-pocket costs of an active single for the following medical services: 1 wellness visit, 1 primary care visit, 1 specialty care visit and 1 urgent care visit.



**The HRA 1000 plan provides a member $1,000 ($2,000 family) to offset medical costs. This offset has been included in the charts below.*
***The HRA 775 plan provides an active member $200 and up to a $575 dollar-for-dollar match to be deposited into the members health savings account. The chart assume the member will at least deposit the $575 into the HSA in order to receive the state match.*
Note: *These notes pertain to Chart 4 on the next page as well.*

Based upon Chart 6 above, if an individual merely has traditional routine medical service needs, it is possible for this individual to save total costs with a consumer driven plan as opposed to the current traditional plans and proposed traditional plans. However, Chart 7 on the next page reflects the total

out-of-pocket costs with the same routine medical services provided, but additionally includes an in-patient hospital stay.



Based upon Chart 7, by including the in-patient hospital stay along with routine medical services, the consumer driven plan options are more costly to the member. However, the DOA/OGB contends that because only 7% of the current HMO population experience in-patient stays, the odds may be in member's favor if a consumer driven plan is chosen. For every year of low utilization there will be more resources available to the member in the HRA/HSA accounts to offset these costs because these funds can be carried forward from health plan year to health plan year. Based upon the single active scenario previously discussed, the risk to the OGB member within this illustration is approximately $1,000 to $2,000 of potential additional out-of-pocket medical expenses versus a gain of $500 to $1,000.

Under a similar scenario for an active family of 4, the potential cost savings of having a *good health plan year* ranges from $2,000 to $4,500 depending upon plan comparisons, while the risk of choosing a consumer driven health plan equates to a potential cost increase of $1,400 to $3,200. This risk assessment assumes only 1 member of a family of 4 has an in-patient hospital stay.

OPTIONS UTILIZED BY OGB

In order to manage a self-insured group health insurance plan there are 7 major items that can be modified to assist in the management of the plan. These items include: raising premiums, modifying benefits, increasing the employee cost share, reducing provider rates (network administration), producing better health outcomes (wellness initiatives), decreasing utilization and reducing administrative overhead. Based upon the proposed health plan changes, the DOA/OGB is incorporating a multi-step approach to stop the current negative monthly burn rate. Table 5 below provides a brief summary of the options already implemented by the DOA/OGB as well as the options being implemented effective January 1, 2015. As previously discussed, even after all the anticipated health plan changes are implemented, the negative burn rate for FY 15 is anticipated to be $7.4 M, or an annualized negative fund balance impact of $88.2 M.

OPTIONS UTILIZED BY DOA/OGB (Table 5)

Self-Insurance Health Plan Options	Description
Raise Premiums	Effective July 1, 2014, premiums increased by 5% which resulted in additional revenues in the amount of $57.9 M flowing into the OGB.
Modification of Benefits such as eliminating routine vision	Some benefit changes include: eliminating routine vision benefits and limiting out-of-network benefits (2 of 6 health plan options) all effective January 1, 2015.
Increase Cost Share	Increasing out-of-pocket maximums and copayments for health plans effective January 1, 2015. Also, implementing a 3-tier drug formulary effective August 1, 2015 that includes a reduced generic drug costs and an increased brand name drug cost.
Reduce Provider Rates	According to the DOA, this occurred when Blue Cross Blue Shield (BCBS) took over the administrative functions of the HMO Plan and PPO Plan. According to the DOA, BCBS has lower provider discounts to the member than the original OGB PPO provider network or the former HMO/EPO administrators could provide.
Better Health Outcomes	OGB has begun implementing their wellness initiatives.
Decrease Utilization	To the extent more members join consumer driven plans and due to higher cost share, consumerism will likely enter into the member's mind when making healthcare decisions for medical care and prescription drug choices, which may decrease overall utilization.
Administrative Overhead	Based upon the latest OGB financials, the Third Party Administrator (TPA) arrangement with Blue Cross Blue Shield (BCBS) for the operation of the PPO Plan to date has reduced overall administrative costs by approximately 15%. Based upon the FY 14 ending year financials, OGB's overall administrative overhead is approximately 4.7% of total expenditures, which is a decrease from administrative overhead of 6.1%, 5.9%and 5.4% in FY 11, FY 12 and FY 13.

ALTERNATIVE OPTION

Fiscal Impact of Just A Premium Increase

One option that has been requested of the LFO is to determine the impact of solving the current negative monthly burn rate with premium increases exclusively. Based upon the current expenditure increase trend of 6% annually and using actual FY 14 base expenditure data, the negative monthly burn rate would increase to $18.6 M/month in FY 15, which equates to a $223 M annualized FY 15 negative fund balance problem. Utilizing these numbers, in order to generate enough premiums to completely offset the anticipated negative burn rate premiums would have to be increased by another 18%, which would generate approximately $223 M in additional revenues. Pursuant to R.S. 42:851, the state (employer) is responsible for 75% of the premium while the employee is responsible for 25% of the premium. For members' dependents, the state is responsible for 50% of the premium and the employee is responsible for the remainder. The current blended employer/employee premium share is approximately 67% state/33% employee.

For **illustrative purposes only**, to the extent premiums are increased another 18% in FY 15, state agencies would be responsible for approximately $96 M of which a significant portion would likely have to be funded with SGF. The remaining portions would come from state employees in the amount of $37.3 M (or $13 per member per month) and from participating school boards in the amount of $89.7 M. The 18% premium increase would be in addition to the 5% premium increase that was effective July 1, 2014. To the extent this actually occurred, OGB members would experience an aggregate 23% premium increase in FY 15.

Note: *The breakdown of the state agency, employee and school board is based upon the percentage breakdown of the 5% premium increase that went into effect on July 1, 2014. This is merely an illustration and may not necessarily reflect the specific fiscal impact of this option.*

Note: *This illustration does not include any potential programmatic savings being incurred from the August 1, 2014 changes. To the extent these savings were included in the illustration above, the 18% premium increase calculation would likely be reduced.*

To the extent the 18% premium increase is paid entirely by the OGB member, based upon the current OGB enrollment data, the per member per month increase equates to approximately $80 per member per month (or $963 per member per year). This likely would require an amendment to R.S. 42:851.

POTENTIAL FY 16 PREMIUM RATE INCREASE

Since the JLCB meeting on September 19, 2014, the LFO has been requested to determine the potential premium increase that may be implemented beginning in FY 16 if all the health plan changes proposed by the DOA/OGB actually result in the projected savings. As has been previously discussed, after all the health plan changes are implemented, OGB's anticipated FY 15 ending year fund balance will be approximately $88.2 M less than the FY 14 ending year fund balance. Based upon the current projections from the health plan changes and based upon FY 14 actuals, premiums would have to be increased by 7.2% in FY 16 to completely stop the anticipated FY 15 negative burn rate of $7.4 M per month.

For **illustrative purposes**, to the extent premiums are increased 7.2% beginning July 1, 2015 (FY 16), state agencies would be responsible for approximately $38.4 M of which a significant portion would likely require SGF resources. The remaining portions would come from state employees in the amount of $14.9 M (or $5 per member per month) and from participating school boards in the mount of $35.9 M.

Sources of Information

American Health Insurance Plans (AHIP) Center for Policy & Research. "January 2014 Census Shows 17.4 million Enrollees in Health Savings Account-Eligible High Deductible Health Plans." July 2014.

Barro, Josh. "Cadillac Coverage: The High Cost of Public Employee Health Benefits." Civic Report: Center for State & Local Leadership at The Manhattan Institute. 65, (2011): 1-9.

Buchmueller, Thomas. "Consumer-Oriented Health Care Reform Strategies: A Review of the Evidence on Managed Competition and Consumer-Direct Health Insurance." The Milbank Quarterly: A Multidisciplinary Journal of Population Health and Health Policy. 87.4, (2009): 820-841.

Charlton PhD, Mary, Barcey Levy, PhD, MD, Robin High, MBA, MA, John Schneider, PhD and John Brooks, PhD. "Effects of Health Savings Account—Eligible Plans on Utilization and Expenditures." The American Journal of Managed Care. 17.1, (2011): 79-86.

Centers for Disease Control and Prevention, "Chronic Diseases: The Power to Prevent, The Call to Control" (2009),
http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf

Fronstin PhD, Paul, Martin-J Sepulveda, MD, and Christopher Roebuck, PhD, MBA. "Medication Utilization and Adherence in a Health Savings Account-Eligible Plan." The American Journal of Managed Care. 19.12, (2013): 400-407.

Geyman, John. "Cost-Sharing Under Consumer-Driven Health Care Will Not Reform US Health Care." Journal of Law, Medicine & Ethics. Fall (2012): 574-581.

Iskarpatyoti, Lale. "What's Next for Consumer-Direct Health Plans?" Benefits Quarterly. First Quarter, (2010): 39-42.

Kaiser Family Foundation. "Health Insurance Coverage of Population." 2012.

PEW Charitable Trusts & MacArthur Foundation. "State Employee Health Plan Spending: An examination of premiums, cost drivers and policy approaches." August 2014.

Wilson, Amy, Eric Bargman, Derek Pederson, Annikka Wilson, Nancy Garrett, David Plocher and Philip Ailiff Jr. "Health Care Utilization in a Consumer-Driven Health Plan." Benefits Quarterly. First Quarter, (2008): 46-54.

HEALTH INSURANCE DEFINITIONS

Based upon research, the LFO has provided definitions of commonly used health insurance terms that are utilized throughout this document. The source of the prescription drug terms is from MedImpact's presentation to the OGB board on July 30, 2014. MedImpact is OGB's pharmacy benefit manager. This has been previously provided for review in the August 2014 LFO memo to the committee. This list is provided again for your use.

- ***Premium*** *– Amount of money a member pays monthly for health insurance.*
- ***Deductible*** *– Amount of money a member pays for eligible medical expenditures. After the deductible is met, the health plan pays 100% or the member shares the costs (coinsurance) with the health plan up to the out-of-pocket maximum (like the proposed OGB health plan options). The deductible is typically different for in-network and out-of-network providers. All new health plan options have different deductibles for in-network and out-of-network, excluding the Local/Local Plus health plans which have no out-of-network benefit at all.*
- ***Coinsurance*** *– Health cost sharing between the OGB member and the health plan. Cost share ranges included in the new OGB plan offerings range from 90/10 to 80/20, whereby the health plan pays either 90% or 80% of the medical service cost and the member pays the balance up to the out-of-pocket maximum.*
- ***Out-of-pocket Maximum*** *– The maximum amount of money an OGB member pays out-of-pocket for medical services in a health plan year. Under the OGB health plan offerings, co-pays, coinsurance and deductibles are all included in the out-of-pocket maximum calculation. The out-of-pocket maximum typically varies for in-network and out-of-network providers.*
- ***Health Savings Account (HSA)*** *– A savings account that is utilized in conjunction with a high deductible health insurance policy that allows an individual to save money tax-free in an account for medical expenses. Depending upon the employer policy, contributions are made to the account by the employer and employee and these funds can follow the employee.*
- ***Health Reimbursement Arrangement (HRA)*** *– An employer funded account that reimburses employees for out-of-pocket medical expenses. HRAs are notional accounts and the funds cannot follow the employee. In addition, only the employer can contribute to the account.*
- ***Generic Drugs*** *– Identical to a brand name drug in dosage, strength, effectiveness and safety.*
- ***Preferred Brand Drugs*** *– Drugs that have been on the market and do not have a generic equivalent available.*
- ***Non-preferred Brand Drugs*** *– Higher-cost medications that have recently come on the prescription drug market.*
- ***Specialty Medications*** *– Brand or generic drugs that cost over $600 and typically treat specific diseases such as Cancer, Multiple Sclerosis and Rheumatoid Arthritis.*
- ***Balanced Billing*** *– The practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as "reasonable and customary" amount. If the health plan does not have an out-of-network benefit, the OGB member would be responsible for the entire medical costs of the out-of-network provider.*